PATIENT INFORMATION FORM: PLEASE PRINT

Please fill this form out completely – **ALL INFORMATION IS REQUIRED**

PATIENT INFORMATION:

FIRST NAME ______________________________ MIDDLE INITIAL _______ LAST NAME ____________________________________

ADDRESS____CITY __________________________ STATE _______ ZIP____________

DOB_____________________ SEX: MALE FEMALE PHONE # _______________________

PARENT OR LEGAL GUARDIAN INFORMATION:

FIRST NAME_________________________________ LAST NAME____________________________________ DOB _____________

ADDRESS____ CITY ___________________________STATE _____ ZIP____________

HOME PHONE___________________________ CELL PHONE__________________________ WORK PHONE____________________

EMPLOYER____

PARENT OR LEGAL GUARDIAN INFORMATION:

FIRST NAME_________________________________ LAST NAME____________________________________ DOB _____________

ADDRESS____ CITY ___________________________STATE _____ ZIP____________

HOME PHONE___________________________ CELL PHONE__________________________ WORK PHONE____________________

EMPLOYER____

PRIMARY INSURANCE: IS THIS AN AFFORDABLE CARE MARKETPLACE PLAN? Y N IF YES, PLEASE STOP AND SEE THE FRONT DESK

INSURANCE NAME___________________________________ADDRESS____

POLICY HOLDER_______________________________________DOB___________ADDRESS__________________________________

ID#___________________________ GROUP#______________________ SS# IF NEEDED FOR BILLING___________________________

SECONDARY INSURANCE: IS THIS AN AFFORDABLE CARE MARKETPLACE PLAN? Y N IF YES, PLEASE STOP AND SEE THE FRONT DESK

INSURANCE NAME___________________________________ADDRESS____

POLICY HOLDER_______________________________________DOB___________ADDRESS__________________________________

ID#___________________________ GROUP#______________________ SS# IF NEEDED FOR BILLING___________________________

PLEASE LIST ALL CHILDREN IN YOUR FAMILY WHO COME TO HAND IN HAND PEDIATRICS:

_______________________________________ ____________________________________ _____________________________

_______________________________________ ____________________________________ _____________________________

NEAREST NON-PARENT RELATIVE OR FRIEND <u>NOT</u> LIVING WITH YOU:

NAME:____RELATIONSHIP:______________________PHONE:______________________

HOW WERE YOU REFERRED TO THIS PRACTICE?

EXISTING PATIENT _____ PHYSICIAN _____ NAME OF PATIENT OR PHYSICIAN: ____

NEWSPAPER _____ TELEPHONE _____ INTERNET _____ HAND IN HAND WEBSITE _____ INSURANCE CO _____

OTHER ____